UnitedHealthcare Medicare Advantage hospice VBID

Out-of-network provider guidance

Purpose

This document is intended to provide guidance to out-of-network hospice providers serving UnitedHealthcare members whose plans are included in the hospice benefit component of the Center for Medicare & Medicaid Innovation (CMMI) Value-Based Insurance Design (VBID) demonstration.

The CMMI hospice VBID model aims to achieve the following outcomes:

- Enable a seamless continuum of care for members electing hospice care and help ensure that hospice enrollees do not need to initially decide between continuing the curative care they are receiving or enrolling into hospice care without curative services
- Improve the quality of members' transitions into hospice care and help ensure that members enroll in quality hospices at the most appropriate time during their care journeys
- Foster innovative partnerships between Medicare Advantage organizations (MAOs) and hospice providers

Participating in-network providers for the 2022 hospice VBID demonstration have executed contracts with UnitedHealthcare and have completed the required Medicare credentialing. All other providers who care for members in UnitedHealthcare® Medicare Advantage plans will be considered out-of-network.

Scope

This document applies to out-of-network providers serving UnitedHealthcare Medicare Advantage members in the following plans. Please note that member plan numbers can be found on their UnitedHealthcare member ID card.

Guidance related to Corpus Christi, Texas is at **Hospice VBID.**

State	Area	Centers for Medicare & Medicaid Services (CMS) contract
Alabama	All	H0432-003-000, H0432-004-000, H2802-041-000, H6528-033-000, H0432-012-000, H0432-010-000, H0432-009-000, H2802-044-000, H0432-013-000, H1889-009-000
Illinois	Chicago only	H8768-005-000, H8768-010-000
Oklahoma	All	H3749-001-000, H3749-017-000, H3749-018-000, H3749-020-000, H8768-008-000, H8768-009-000, H8768-016-000, H8768-028-000, H5322-031-000, H0271-053-000, H5322-033-000

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UnitedHealthcare hospice VBID model overview

Effective Jan. 1, 2022, the hospice benefit component of the CMMI VBID model changed the UnitedHealthcare Medicare Advantage member's benefits and how hospice services are billed in certain states. The hospice VBID demonstration tests a hospice "carve-in" model that shifts risk and responsibility for hospice care from the CMS to MAOs. Under the model, hospices will continue to provide the services that CMS classifies as being covered in the hospice per diem payment.

Under the hospice VBID model, in states and jurisdictions where UnitedHealthcare has been approved to offer such benefits, UnitedHealthcare will be responsible for coverage and payment of all hospice- related services for Medicare Advantage members who were formerly covered by Original Medicare. Members will remain enrolled in Medicare Advantage while receiving hospice services.

The hospice VBID model aims to ease care transitions, improve quality and timely access to the hospice benefit and remove barriers to both palliative and hospice care so that members may choose hospice at a more appropriate time in their care journey. Under this model, UnitedHealthcare will offer additional services that may not be currently included in the Original Medicare coverage for hospice. When a member elects to enroll in an in-network hospice, additional benefits such as transitional concurrent care [(TCC) e.g., transitional curative services] and continued care navigation will be available to them — these benefits are not available if a member elects hospice with an out-of-network provider. The hospice VBID model focuses on creating a more seamless transition into end-of-life care through improved continuity and transitional care for our members during their Medicare Advantage experience.

Eligibility

Confirming a member's eligibility

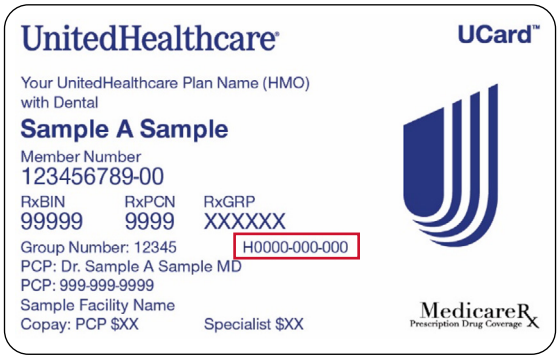
If a member is in a VBID participating UnitedHealthcare Medicare Advantage plan, and the eligible member hospice election date is on or after the eligibility date of the Plan Benefit Package, UnitedHealthcare will be financially responsible for hospice services. For plans outside the VBID model, when a Medicare Advantage plan member elects to enter hospice, Original Medicare is financially responsible for most Medicare-covered services. UnitedHealthcare is financially responsible for some services unrelated to terminal illness.

State	Area	Centers for Medicare & Medicaid Services (CMS) contract	Plan eligibility date
Alabama	All	H0432-003-000, H0432-004-000, H2802-041-000, H6528-033-000, H0432-012-000, H0432-010-000, H0432-009-000, H2802-044-000, H0432-013-000	Jan. 1, 2022
Alabama	All	H1889-009-000	Jan. 1, 2023
Illinois	Chicago	H8768-005-000, H8768-010-000	Jan. 1, 2022
Oklahoma	All	H3749-001-000, H3749-017-000, H3749-018-000, H3749-020-000, H8768-008-000, H8768-009-000, H8768-016-000, H8768-028-000, H5322-031-000, H8125-003-000	Jan. 1, 2022
Oklahoma	All	H0271-053-000, H5322-033-000	Jan. 1, 2023

The presence of a contract number that matches a contract listed above does not mean that the member is still active in the plan. Eligibility still needs to be confirmed.

Hospice providers can confirm member eligibility by checking a member's plan through the **Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) through CMS** or at **Eligibility and Benefits.**

The plan number is listed on the member's UnitedHealthcare ID card.



Plan changes

If a member who is in an active hospice election chooses to switch to another participating plan, the hospice benefit coverage will remain. However, if the member chooses to "opt out" of the MAO plan to Original Medicare (e.g., special enrollment periods) or move into a non-participating plan, then the original plan will cover hospice and hospice-related services through the end of the month.

If a member is already on hospice and enrolls in a VBID participating plan, UnitedHealthcare will become the payer on the first day of the month coverage begins. Original notice of election (NOE) will need to be submitted to UnitedHealthcare to ensure claims payment.

Hospice providers should regularly review patients' coverage for continual awareness of the benefits associated with their plan and to remain aware of any plan changes.

Hospice termination and re-election

Claims for members enrolled in hospice on or before Dec. 31, 2021, will continue to be paid by Original Medicare if the member's hospice election remains active. Claims should continue to be sent only to the Medicare administrative contractor (MAC).

Payment will be covered by UnitedHealthcare for eligible services. Only members who elected hospice on or after Jan. 1, 2022, will be included in the model.

If a member revoked hospice election and subsequently elected hospice on or after Jan. 1, 2022, they will be included in this model, and both notices and claims should be sent to both the MAC and UnitedHealthcare.

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Hospice pre-approval

UnitedHealthcare does not require members to receive pre-approval for hospice care. UnitedHealthcare coverage of hospice services is not conditional of a member receiving pre-approval for hospice services. In accordance with 42 CFR § 418.22, hospice providers will continue to obtain certification of terminal illness.

Prior authorizations

Prior authorizations for hospice services are not required from participating Medicare Advantage plans.

Palliative care

In 2023, UnitedHealthcare offers qualifying members home-based palliative care services through Landmark Health. The program is available to members with advanced illness who have begun a process of progressive and significant decline. It is meant to help bridge gaps for those who are not ready or clinically appropriate for a hospice level of care but need additional supportive services. The interdisciplinary care team co-manages directly with the member's primary care provider (PCP) and specialists to manage pain, symptom relief and clinical interventions.

Unlike the Medicare hospice benefit, palliative care does not have a prognosis restriction and may be provided together with curative treatment at any state of a serious illness.

The goal of palliative care is to improve quality of life for those living with serious illness and their families and caregivers by providing specialized medical care, support and relief from the symptoms and stress of a serious illness, while allowing the necessary space and time for enrollees to understand their care choices and decide on a plan of care that best reflects their needs and wishes.

In addition to the benefits that are currently covered by MAOs today, participating VBID plans must also include palliative care and a strategy for advanced care planning, both of which CMS sees as paths to improving end-of-life care. The VBID model requires that UnitedHealthcare has a strategy for engaging members in non-hospice palliative care services. The UnitedHealthcare strategy includes continuing to work with Landmark to provide home-based palliative care services for qualified members.

Referring UnitedHealthcare members to a UnitedHealthcare palliative care program

If it is determined that a member is not ready for hospice care, they may be a candidate for a UnitedHealthcare palliative care program.

For VBID plan members in Alabama, Illinois (Chicago only) and Oklahoma, referring physicians or hospice agencies are to send the referral and patient's demographic information to Landmark via the following methods:

- **Phone: 833-753-2970**
- **Fax:** 866-401-8095

Palliative program transitions to hospice

While Landmark co-manages with the patients' PCPs, they do have the capability to act as the PCP for those patients who do not have one. Landmark's comprehensive care is provided through an interdisciplinary team of physicians (board certified in internal medicine, geriatrics, palliative care and/or hospice), nurse practitioners, nurses and social workers.

The Landmark team is available to patients, families and providers 24/7 for any needs. Additionally, Landmark partners along with other medical providers, specialty physicians and community providers will coordinate all aspects of care to help ensure patients and caregivers are supported where they are most comfortable — at home.

Landmark will provide continual support to patients across the informational, referral and enrollment processes as patients and their families consider if hospice care is the right choice. Landmark will educate patients about their in- and out-of-network provider options.

Pre-hospice consultation via Landmark palliative

A pre-hospice consultation is designed to assist members and/or caregivers by providing information and education on end-of-life care options, including hospice. A pre-hospice consultation is an optional benefit available 24/7 to all members in participating plans. Members receiving Landmark medical services also have the option of receiving the pre-hospice consultation as part of their service offering.

Landmark members can receive a pre-hospice consultation by reaching out directly to their Landmark provider. Or to be connected to a member of the UnitedHealthcare pre-hospice consult team at Optum Hospice Guide, a member can call the number on their member ID card or call the pre-hospice consultation team directly at **833-753-2970.**

Pre-hospice consultation

What to expect during a pre-hospice consultation

The pre-hospice consultation is an **optional** benefit available 24/7 to **all** members in participating plans, at a $0 cost share whether or not they are receiving Landmark palliative medical services. All members can access the UnitedHealthcare pre-hospice consult team (Optum Hospice Guide Care Advocates) by calling the number on their member ID card, or by calling the pre-hospice consultation team directly at **833-753-2970.**

The pre-hospice consultation can help address any questions members may have about hospice care, and will include topics such as:

- General overview of hospice
- Available services through hospice
- Hospice enrollment process
- Collaboration with patient's PCP
- Information about in- and out-of-network hospice providers and options
- In- and out-of-network differences that result from electing hospice services from a hospice provider that participates in the UnitedHealthcare VBID network as opposed to a provider who does not participate in the VBID network

- Information about TCC and identification of potential services presenting barriers to hospice election
- Information about navigational support services for members and their caregivers when choosing a network participating hospice provider

The value of the UnitedHealthcare hospice network will be emphasized during the consultation, and members will be informed that TCC and navigational support services are only available when they choose an in-network hospice.

The member owns the decision to elect hospice, as well as the hospice selection. Neither UnitedHealthcare, nor the hospice can make or change the member's hospice election. Members will be informed that if they choose an out-of-network hospice, payment will be made on their behalf by their UnitedHealthcare Medicare Advantage plan.

Additional information about the voluntary pre-hospice consultation can be found within the CMMI RFA and Technical and Operational Guideline documents at **CMS.gov.**

Hospice benefit

All members who elect hospice will be able to receive hospice care within any of the 4 Medicare-defined hospice levels as appropriate. The member cost shares for hospice care under the VBID demonstration will be identical to the standard hospice cost shares applied today by Original Medicare. In alignment with Original Medicare, members will have the following cost shares:

- $0 cost share for hospice care for any hospice provider regardless of UnitedHealthcare network status
- $5 cost share for each drug provided by their hospice provider
- 5% cost share of the daily respite care rate

Notices and claims

Under the hospice VBID model, CMS requires hospice providers to submit required notices and claims to **both the MAC and to UnitedHealthcare.** These notices include:

- NOE
- Notice of Termination or Revocation (NOTR)
- Notice of Transfer

Please see submission guidance for each in the corresponding sections below.

All notices and claims should be sent to UnitedHealthcare electronically. The method of transmission should be via Electronic Data Interchange (EDI) on the 837, directed to the UnitedHealthcare Payer ID. The Payer ID can be found on the member's ID card. For Illinois, Alabama and Oklahoma plans included in the model, the Payer ID is 87726.

If a provider is unable to submit notices via 837, Optum EDI may be used as an alternative submission portal. Resources for Optum EDI NOE submission can be found on the **UnitedHealthcare VBID webpage.**

Hospice providers are to submit both claims and notices only to the MAC if:

- A member was actively enrolled in hospice care prior to Jan. 1, 2022
- A member "opts out" of the MAO plan or moves into a non-participating plan. Note: The original plan will cover hospice and hospice-related services through the end of the month.

Hospice providers are to submit claims and notices to both the MAC and UnitedHealthcare if:

- The current NOE became active on or after Jan. 1, 2022
- A member was actively enrolled in hospice before Jan. 1, 2022, revoked their hospice care and re-elected hospice on or after Jan. 1, 2022
- If a member switches into a participating VBID plan, after electing hospice after Jan. 1, 2022, under Original Medicare, then UnitedHealthcare would be responsible for claims on the first day of the following month
  - The original NOE must be submitted to UnitedHealthcare when a member switches to a VBID participating plan while the member is receiving hospice care

Notices submission requirements

Notices must be submitted to both the MAC and UnitedHealthcare within the time frames outlined below. Consistent with CMS requirements, if notices are not submitted in a timely manner, the hospice provider risks payment delays and/or reduction in payment.

Notice of Election

Hospice providers must submit the NOE within 5 calendar days of hospice admission to both the MAC and UnitedHealthcare. An NOE must be on file with UnitedHealthcare for claims to process.

Notice of Termination or Revocation

If a member chooses to revoke their hospice care election, the hospice provider must provide the MAC and UnitedHealthcare with a NOTR within 5 calendar days after the effective date of discharge or revocation.

A NOTR should **not** be used when a patient is transferred. Hospice providers must also contact the Optum Hospice Guide Care team by phone to notify of discharge date and disposition within 24 hours of discharge. To do so, call **833-753-2970** or email **HospiceCareCoordination@optum.com.**

Notice of Transfer

If a member chooses to transfer from one hospice agency to another, the hospice agency that the beneficiary is transferring from submits a final claim. After the transferring hospice has submitted their final claim, the admitting hospice then submits a hospice Notice of Transfer.

Notifying Optum Hospice Guide Care team of death or discharge

Please notify the Optum Hospice Guide Care team by phone **(833-753-2970)** or email **HospiceCareCoordination@optum.com** within 24 hours of member death or discharge.

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Billing and claims

Methodology

Under the hospice VBID model, hospice providers will provide the services that CMS classifies as being covered in the hospice per diem payment. UnitedHealthcare will reimburse contracted providers, according to CMS Standard Hospice Payment Methodology, based on the number of days and level of care provided during the member's hospice election period.

How to submit claims

For members in the VBID demonstration plans (Page 3) who elect hospice on or after Jan. 1, 2022, CMS requires providers delivering hospice services to submit hospice care claims to both UnitedHealthcare and the MAC. Billing instructions can be found on the **CMS hospice VBID information site.**

When to expect payment

UnitedHealthcare is required to pay all clean claims within 30 days of receipt. Out-of-network hospice providers will be reimbursed at 100% of Original Medicare rates.

Note:
Claims will be denied if an NOE is not on file. Hospice providers must be loaded in the UnitedHealthcare system for hospice claims to process. If a provider has never billed UnitedHealthcare before, please email **hospicevbid@uhc.com** with the following prior to submitting claims: Provider name, billing address, billing contact information, Medicare ID, NPI, TIN and W-9.

Where to call with questions about claims

For any claims-related questions and/or inquiries, providers can contact the customer service number listed on the member's ID card. You may also contact the UnitedHealthcare VBID team at **952-931-4041** or by email at **hospicevbid@uhc.com.**

Additional resources for notices and claims

- **Medicare Claims Processing Manual; Chapter 25 – Completing and Processing the Form CMS-1450 Data Set**
- **Medicare Benefit Policy Manual, Chapter 9 – Coverage of Hospice Services Under Hospital Insurance**
- **Claims Processing Manual, Chapter 11 – Processing Hospice Claims**

Appeals and grievances

Methodology

Appeals and grievances regarding hospice care will be addressed using the existing appeals and grievances processes for Medicare Advantage plans, except for immediate reviews of a termination of hospice service.

All appeals and grievances are to be submitted to the Medicare Advantage plan by calling the customer service number listed on the member's ID card.

Hospice appeals and grievances are considered time-sensitive and expedited.

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